

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005023	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/11/2012
NAME OF PROVIDER OR SUPPLIER WILLIAM N WISHARD MEMORIAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 W 10TH ST INDIANAPOLIS, IN 46202		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for the investigation of one State complaint.</p> <p>Complaint Number: IN00101131 Unsubstantiated: Lack of sufficient evidence</p> <p>Facility #: 005023</p> <p>Survey Dates: 04-11-12</p> <p>Surveyor: Billie Jo Fritch RN, BSN, MBA Public Health Nurse Surveyor</p> <p>William N. Wishard Memorial Hospital was found in compliance with 410 IAC 15-1.6.2, Emergency services, 410 IA 15-1.5-8, Physical plant, maintenance and environmental services, and 410 IAC 15-1.5.2, Infection control, Hospital Licensure Rules.</p> <p>QA: cloughlin 04/20/12</p>	S 000		

Indiana State Department of Health

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

KIQ211

If continuation sheet 1 of 1